

## **PSJ2 Exh 30**

*Nursing2008*

# PAIN







# MANAGEMENT

## survey report

**How sharp are you about pain management?  
See how your responses to this survey compare with those  
of nursing colleagues across the country and beyond.**

By Yvonne D'Arcy, CRNP, CNS, MS

IN THE AUTUMN of 2007, I asked nurses to complete a survey on their pain management knowledge, attitudes, and practices. My goal was to learn if nurses understand the principles of pain management and apply current standards and best practices when they care for their patients. From across the United States and beyond, 2,949 nurses responded. (See *Respondent snapshot* for a profile of survey respondents.)

Overall, the results were encouraging, with most respondents demonstrating a good understanding of pain management principles. But the results also pinpointed areas where nurses may need more education, such as pain assessment and the appropriate use of opioid analgesics.

Many nurses provided lengthy and passionate personal comments, many of which were truly inspiring. But as I read through the comments, certain frustrations became apparent.

### Exploring common themes

One of the most common frustrations nurses identified in their comments were concerns with **physician prescribing patterns**, such as prescribing too little medication or the wrong medication for the patient's condition. I encourage nurses who are having this problem to look at ways to solve the issues through education and the use of formulary protocols (see "Using a Medication Protocol to Improve Pain Management," *Nursing Management*, March 2008).

**Pain assessment** just never seems to get any easier. Although this survey demonstrated that nurses generally have a good grasp of many facets of pain management (as I'll discuss in detail shortly), many remain misinformed on certain key issues. For example, about 80% of respondents believe—incorrectly—that an increase in vital signs is a reliable indicator that a patient is experiencing pain.

Some nurses also have issues related to **believing the patient's report of pain**. Most nurses know that the patient's self-report of pain is the most reliable indicator of pain, yet many remarks in the comments section belied this understanding. For example, some nurses commented on trying to determine the "real" status of pain

in patients they described as “drug seeking,” “frequent flyers,” or “clock-watchers.” Despite what they say, in practice some nurses have trouble believing the patient’s report of pain and are overly vigilant when observing for behaviors they interpret as drug seeking.

**Fear of triggering addiction to opioids** was also a frequently voiced concern, even though most respondents (89%) know that less than 1% of patients receiving short-term opioid therapy for acute pain become addicted.

For more discussion of these and other key issues, let’s examine each survey question in turn. Please note that percentages have been rounded and that not all respondents answered every question.

## ■ Don’t rely on vital signs

### 1. Increases in vital signs are an indication that the patient is experiencing pain.

**FALSE. Correctly answered by 20%.**

Vital signs may increase for brief periods with acute pain, but this may not occur in patients with chronic pain.<sup>1</sup>

Besides pain, an increase in vital signs can signal many other problems, such as anxiety or deterioration in the patient’s clinical status. Conversely, a patient with chronic pain may be experiencing severe pain with no changes in vital signs if he’s adjusted to the higher pain intensity over time.

The best way to tell if the patient is experiencing pain is to ask him.<sup>1</sup> Self-report, not physiologic changes, is still the gold standard for assessing pain.

## ■ I.M. injections aren’t recommended

### 2. Intramuscular (I.M.) injection is a good way to deliver pain medication.

**FALSE. Correctly answered by 75%.**

For many years, I.M. injection was the standard for delivering pain medication. Current practice discourages this method for several very good reasons: Medication absorption is irregular, muscle tissue can be damaged,

and I.M. injections are painful.<sup>1</sup>

Most (75%) survey respondents in all age-groups and educational preparation levels were aware that I.M. injections aren’t the best practice. Older, more experienced nurses have adjusted their practice to meet current standards.

## ■ Sleep isn’t always pain-free

### 3. A patient may sleep despite being in pain.

**TRUE. Correctly answered by 94%.**

As most respondents know, patients can sleep despite pain, especially those who’ve been living with pain for a long time and are exhausted. In the past, nurses typically perceived the sleeping patient as being comfortable, so this high proportion of correct answers reflects a significant advance in nurses’ knowledge and attitudes.

## ■ Depression plays a part

### 4. Depression is common in patients who have chronic pain.

**TRUE. Correctly answered by 98%.**

Many patients with chronic pain suffer from depression; as a patient group, they have an increased risk of suicide.<sup>2</sup> A long period of pain coupled with deterioration in the patient’s functional ability and relationships can cause a situational depression that affects pain relief, rest, and interpersonal relationships. Sometimes treating the depression makes controlling pain easier. Nearly all respondents to this survey were aware of the truth in this statement, an encouraging finding.

## ■ Whose pain is it?

### 5. A nurse can tell how much pain a patient is experiencing by closely observing him.

**FALSE. Correctly answered by 82%.**

You can’t tell how much pain a patient is experiencing just by watching his activity level, and observing his behavior is no substitute for patient self-report if he can communicate and rate pain intensity. If he leaves the unit to smoke or go to the gift shop, for example, that doesn’t mean he’s having no pain. Patients with chronic pain accommodate to higher pain levels and may continue to function despite intense pain. And some patients are very stoic or ashamed of their pain and try to hide it from others.

Health care professionals tend to do poorly when they rate a patient’s pain based on their observations. In one study comparing patients’ pain ratings with those of health care professionals, the patients rated their pain from 7 to 10 on a 0-to-10 numeric scale. The percentages of health care professionals who correctly matched the patients’ ratings were very low: nurses, 7%; house officers, 20%; and fellows, 27%.<sup>3</sup> Remember, you can’t experience someone else’s pain, and observing his behavior won’t provide the information you need to assess his pain.

Only about 20% of respondents replied incorrectly to this survey item, with nursing students having the highest deviation from the correct answer. This has important implications for nurse-educators. When nursing students are in clinical rotations, nurse-educators need to provide them with direction on how to assess pain correctly and avoid the pitfall of observation rather than appropriate pain assessment techniques.

## Respondent snapshot

Here’s an overview of nurses responding to this survey:

- **primary work setting:**  
hospital, 71%
- **current position:**  
staff/primary nurse, 53%
- **primary clinical area:**  
medical/surgical, 29%  
ICU/CCU, 10%  
geriatrics, 9%
- **highest educational level:**  
BS/BSN, 36%  
AD, 20%  
RN diploma, 16%  
MS/MSN, 15%  
LPN/LVN, 6%
- **years of nursing experience:**  
over 15, 58%  
5 or less, 20%
- **age:**  
over 50, 40%  
41-50, 30%  
31-40, 19%
- **practice location:**  
urban, 42%  
suburban, 33%
- **certified in a specialty:**  
no, 63%



### ■ What if the patient can't communicate?

6. Behavioral pain scales using behaviors such as grimacing, moaning, or rubbing are effective for assessing pain in nonverbal patients.

**TRUE. Correctly answered by 91%.**

Now that The Joint Commission requires pain assessments for all patients, using behavioral pain scales for patients who can't self-report pain has become common. Some of the newer tools include the Pain Assessment in Advanced Dementia scale for patients with dementia and the Payen behavioral pain scale for critically ill, sedated, and mechanically ventilated patients.<sup>4,5</sup> By using the same tool each time, nurses can consistently assess pain in nonverbal patients.

### ■ Drug seeking or relief seeking?

7. Patients who exhibit behaviors such as clock-watching are showing signs of addiction.

**FALSE. Correctly answered by 80%.**

Patients who watch the clock or know just when the next medication dose is due are likely to be suffering from undertreated pain, not addiction. Once pain is relieved, these behaviors tend to disappear. Rather than considering these patients as drug seeking, think of them as relief seekers trying to obtain adequate medication.

Most nurses responding to the survey understood this differentiation, with only about 20% indicating that clock-watching is a sign of addiction. See *Understanding aberrant drug-related behavior* for a list of behaviors that are more predictive of addiction.

### ■ PCA has limitations

8. Continuous infusion via patient-controlled analgesia (PCA) pumps is a good way to provide analgesia for all patients.

**FALSE. Correctly answered by 83%.**

Patient-controlled analgesia lets the patient give himself intermittent bolus doses as needed to manage pain. In the past, PCA pumps were often set to deliver a continuous basal intravenous (I.V.) infusion as well. But we now know that continuous infusions via PCA may cause oversedation and respiratory depression yet add little to pain relief. Consequently, continuous basal infusions via PCA are no longer recommended for opioid-naïve patients.<sup>1,2</sup> However, some opioid-tolerant patients who were taking opioids before PCA therapy, such as oncology patients and those being treated for chronic pain, may require a continuous infusion to manage pain, so this option should remain available for them.

Most respondents to the survey were up-to-date with their information on this point, with only 17% answering incorrectly.

### ■ Opioid polymorphism plays a role

9. Differences in mu (opioid) binding sites account for differences in patient response to opioids.

**TRUE. Answered correctly by 93%.**

Opioid polymorphisms, defined as differences in patient response to opioids based on physiology, has become a new area of pain management research. To date, at least 45 different types of opioid binding site variations have been identified.<sup>6</sup> These variations mean that based on their physiology,

## Understanding aberrant drug-related behavior

Aberrant drug-related behaviors are maladaptive but not always predictive of addiction risk in patients with chronic pain.

Probably more predictive of addiction	Probably less predictive of addiction
<ul style="list-style-type: none"> <li>• Prescription forgery</li> <li>• Selling prescription drugs</li> <li>• Stealing or borrowing another patient's drugs</li> <li>• Injecting oral formulation</li> <li>• Obtaining prescription drugs from nonmedical sources</li> <li>• Concurrent use of illicit drugs</li> <li>• Unsanctioned dose escalations</li> <li>• Recurrent prescription losses</li> <li>• Evidence of deterioration in the ability to function at work, in the family, or socially that appears to be related to drug use</li> <li>• Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug</li> </ul>	<ul style="list-style-type: none"> <li>• Drug hoarding during periods of reduced symptoms</li> <li>• Aggressive complaining about need for higher doses</li> <li>• Requesting specific drugs</li> <li>• Unapproved use of drug to treat another symptom</li> <li>• Obtaining similar drugs from other medical sources</li> <li>• Reporting psychic effects not intended by the clinician</li> <li>• Unsanctioned dose escalations one or two times</li> <li>• Expressing worry over changing to a new drug, even if it would have fewer adverse effects</li> </ul>

Source: Passik SD et al., Pain and aberrant drug-related behaviors in medically ill patients with and without histories of substance abuse, *Clinical Journal of Pain*, 22(2):173-181, February 2006.

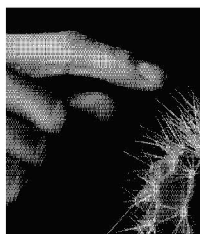
some patients respond better to one opioid than another. A patient who lacks enzymes that allow opioids to bind to the mu site will have great difficulty getting enough medication activated to relieve pain. The fact that 93% of respondents answered this question correctly is truly a sign of progress because this information is newer and less commonly addressed in nursing education.

### ■ Different pain requires different treatment

**10. Management of neuropathic pain, such as diabetic neuropathy, often requires a combination of medications such as opioids and antidepressants for effective pain relief.**

**TRUE. Correctly answered by 88%.**

Neuropathic pain is different from musculoskeletal pain because it results from injury to nerves rather than bones or muscle. Because of this difference, medications designed to decrease nerve pain transmission or prevent pain-related responses are needed. Although not all



**Because they've developed tolerance to opioids, some oncology patients on chronic opioid therapy safely receive very high opioid dosages.**

patients require a combination of medications, combining an opioid with an antidepressant or an antiepileptic drug (AED) is common. For example, the AED gabapentin may be prescribed to help treat chronic neuropathic pain, such as diabetic neuropathy.

To assess your patient's pain, listen to the way he describes it. If he says it's burning, painfully numb, tingling, or shooting, it's most likely neuropathic. One patient described his postthoracotomy pain as feeling "like a blow-torch across my chest." You can help ensure that your patient receives the most effective therapy by documenting verbal descriptors that indicate nerve injury.

### ■ No limit to opioid analgesia

**11. There is no ceiling or upper limit on how far you can increase doses of opioid medication to improve pain relief.**

**TRUE. Correctly answered by 42%.**

Morphine and other opioids, such as fentanyl and hydromorphone, have no ceiling on the degree of pain relief they provide. Raising the dosage increases analgesia, but dosages are limited by the risk of adverse reactions, such as overdose. The dosage of an opioid is also limited when it's combined with another drug, such as acetaminophen, that has a dosage ceiling.

When given I.V., opioids can easily be titrated upward to effect. Because they've developed tolerance to opioids, some

oncology patients on chronic opioid therapy safely receive very high opioid dosages to control the pain of tumor growth and metastasis.

Fewer than half our respondents had a good understanding of these points. Higher educational levels correlated with more correct answers; advanced practice nurses scored the highest percentage of correct answers (70%).

Opioids are commonly given in high dosages in oncology practice. Only about 6% of survey respondents worked in oncology, which may have affected the response pattern.

### ■ Benefits and risks of NSAIDs

**12. Nonsteroidal anti-inflammatory drugs (NSAIDs) used for relief of mild pain cause few adverse reactions.**

**FALSE. Correctly answered by 52%.**

In the past, the main concern for patients who took NSAIDs was the potential for gastric ulceration and gastrointestinal bleeding, particularly with chronic use. In 2005, however, the Food and Drug Administration issued recommenda-

tions related to increased cardiovascular risks such as myocardial infarction and stroke, as well as serious allergic reactions such as Stevens-Johnson syndrome. Currently all NSAIDs have a black-box warning indicating an increased risk of these events. Under current recommendations, patients should use NSAIDs at the lowest effective dose for the shortest time possible.

Certain patients, such as cardiac surgery patients, aren't good candidates for these medications.

Only 52% of survey respondents answered this question correctly. Because NSAIDs are no longer considered as benign as in the past, the patient's history and cardiovascular risk/benefit analysis should be evaluated before an NSAID is included in his ongoing treatment plan.

### ■ Assessing for medication efficacy

**13. In patients with chronic pain, functionality may be a better measure of the efficacy of pain medication than decreased pain levels.**

**TRUE. Correctly answered by 91%.**

The ability of a patient to care for herself or to walk a certain distance is a better indicator of pain medication efficacy than a numeric pain rating. Patients with chronic pain can accommodate to and tolerate more pain.

Medication use has become regulated by opioid contracts in many practices that treat patients with chronic pain.<sup>7</sup>

An opioid contract is a written agreement signed by a patient and his physician at the beginning of treatment. The purpose is to inform the patient about the risks and benefits of opioid therapy, define treatment goals, and document informed consent. Although these contracts aren't legally binding, they may encourage patients to follow the prescribed treatment regimen. These contracts are among the newest elements of opioid management for chronic pain, and little research-based information on



their effectiveness is currently available.

Tools that measure functionality, such as the Oswestry Disability Questionnaire, SF-36 (Short-form 36), and chronic pain tools such as the Brief Pain Inventory and McGill Pain Questionnaire, all include functionality measures. For a quick evaluation of the efficacy of your patient's medication regimen, ask her what activities she can do when using her pain medication versus what she can do without it.

The addition of functionality as part of a normal assessment highlights the goal that both the patient and nurse are trying to reach. Most respondents answered this item correctly, an encouraging sign that nurses are going beyond a minimal numeric assessment of their patients' pain.

### ■ Weighing the placebo response

#### 14. Giving a patient a placebo is a good way to tell if he's really having pain.

**FALSE. Correctly answered by 92%.**

Most respondents recognized this statement as false. Placebos should never be used to determine if a patient's pain is real.<sup>1</sup> Many patients respond positively to placebos, despite the fact that placebos have no active ingredients—a phenomenon recognized as the placebo response. This positive response doesn't mean the patient wasn't in pain.

To give a patient a placebo without informed consent is deceptive and unethical and can destroy her trust in her caregivers. The only time a placebo can be ethically used is in a research setting where the patient is informed that she may receive a placebo as part of the research protocol.

### ■ Addiction and dependency: Questions still remain

#### 15. What percentage of patients who receive opioids for short-term treatment of acute pain (1 to 3 days) will become addicted?

**Less than 1%. Correctly answered by 89%.**

The number of patients in acute care settings who abuse substances is dramatically increasing. One recent study found that up to 60% of trauma patients are actively abusing substances such as alcohol, marijuana, cocaine, or heroin or have a history of substance abuse.<sup>8</sup> This makes managing their pain more difficult. However, most patients without prior substance abuse problems who receive opioid therapy for acute traumatic or postoperative pain don't become addicted. Most patients use the medication to relieve pain so they can become more functional and return home.

The difference between addiction and dependency is clear from their definitions:

**Addiction** is a chronic neurobiologic disease characterized by the four C's: *craving* for the substance, *compulsive* use, lack of *control* over the drug, and *continued* use despite harm.

**Dependency** is a physical state that occurs when the body becomes accustomed to the regular use of the medication.

Abruptly stopping the medication will trigger a withdrawal syndrome in a patient who's dependent on the medication. Patients who are addicted to a drug are also physically dependent on it and will likewise experience withdrawal syndrome if the drug is withdrawn.

With short-term use of opioids, most patients will stop the medications when the acute pain episode resolves. A patient who's addicted needs higher doses of opioids to control pain and will continue to use opioids for reasons other than pain relief long after the pain resolves.

#### 16. What percentage of patients who have chronic pain and use opioids for 1 year become addicted?

**5%. Correctly answered by 40%.**

Although estimating the rate of addiction in patients using opioids to manage chronic pain is difficult, new research indicates a previously unrecognized risk of addiction in this patient group. In a study of 800 patients in primary care practices, the rate of addiction among patients with chronic pain who'd been prescribed opioids by primary care physicians was roughly 4%. This is within the 4% to 6% range estimated in other research. This means that approximately 1 in every 25 patients in the study was abusing opioid medications. Some of the diagnoses for patients in the study were degenerative arthritis, low back pain, migraines, neuropathy, and fibromyalgia.<sup>9</sup>

The low proportion of correct responses to this survey item indicates that the use of opioids to treat chronic pain continues to trouble nurses. Most of the incorrect responses were very high, with 20% predicting that 25% of these patients would become addicted and 13% predicting 50%. Interestingly, however, 27% of respondents indicated the addiction rate was low, less than 1%.

Fear of addiction and misunderstanding of dependency creates a high potential for undertreatment and labeling of patients as drug seekers. Many nurses confuse addiction with aberrant pain behaviors, such as frequent requests for early prescription refills, "lost" prescriptions, drug hoarding, or requests for specific medications or doses. The rates for patients with chronic pain who demonstrate aberrant pain behaviors range from 5% to 24% of the patient population.<sup>10</sup> These behaviors are maladaptive but don't necessarily indicate addiction.

For many years, some well-meaning pain practitioners, while correctly placing pain relief at the forefront of treatment, failed to recognize that some of their patients would become addicted to opioids with long-term use. We now know that for some patients with chronic pain, taking opioids isn't the answer and may in fact create serious new problems.

#### 17. What percentage of addicted patients who abuse prescription opioids can be considered dependent on opioids?

**50% or more. Correctly answered by 54%.**

As I discussed above, all patients who are truly addicted to

opioid medications are also physically dependent and will experience withdrawal if the drugs are abruptly withdrawn. Signs and symptoms of withdrawal include nausea, vomiting, shaking, back pain, gooseflesh, and delirium.

Many nurses confuse dependency and addiction and don't understand how they relate to each other. In this survey, 16% of respondents thought that only 5% of addicted patients would be opioid-dependent; 24% of respondents put the figure higher at 25%.

Any patient who's addicted to opioids, no matter what the source, is also dependent on them. Knowing this is critical to treating his pain appropriately.

#### 18. How comfortable are you giving opioids regularly to a patient who's been taking opioids for 12 months to control chronic low back pain?

35%	Very comfortable
45%	Comfortable
15%	Uncomfortable
4%	Very uncomfortable

The comfort level for providing opioids in this circumstance was very good in the survey respondents, with about 80% claiming to be comfortable or very comfortable giving opioids to an opioid-dependent patient with chronic low back pain. Unreasonable fear of addiction leads many clinicians to undertreat patients with chronic pain, causing them to suffer needlessly. As discussed above, however, from 94% to 96% of patients won't become addicted when using opioids to manage chronic pain.

Among survey respondents, nurses who were least comfortable with providing the opioids were newer nurses with less than 5 years' experience.

#### ■ Is PCA used safely in your practice?

19. Please check all of the following that apply to use of PCA in your practice.

83%	Two nurses must sign when therapy is initiated and with all dosing changes.
69%	Standardized education on PCA use is provided to patients.
68%	Standard order sets are used for PCA.
67%	PCA solutions and concentrations are standardized.
63%	Annual competency on PCA use is required to assess your ability to correctly enter dose settings and parameters.
19%	Nurse-activated PCA or PCA by proxy is permitted.

The Joint Commission and the Institute for Safe Medication Practices recommended certain measures to improve the safety of PCA use, including standardizing order sets, drugs, and drug concentrations used for PCA, requiring annual competency for nurses, and requiring a second nurse's signature for all medication changes.<sup>11-13</sup>

\* Individual subscribers can also access this article free online at <http://www.nursing2008.com>.

#### Does your knowledge match your confidence?

Responding to this survey, 2,897 nurses answered this question: *On a scale of 1 to 5, how confident are you that you answered most of the questions correctly?* Here's how their confidence level matched up with their knowledge.

Confidence level	Score:
	First 14 questions all correct
5 (very confident)	11%
4	45%
3	37%
2	6%
1 (not confident)	2%
	16%
	5%
	2%
	1%
	0%

Nineteen percent of respondents indicated that nurse-activated PCA or PCA by proxy is permitted at their workplace. These practices are controversial and risky because they bypass an important safeguard built into the system: A patient who's comfortable or sedated won't give himself another dose, but a well-intentioned nurse, friend, or family member could cause significant oversedation by delivering an unneeded dose. However, some clinicians argue that it's appropriate in certain settings, such as pediatric units. In this survey, respondents reporting that PCA by proxy is permitted at their workplace tended to be younger nurses working in urban settings. The Joint Commission recommends that facilities permitting these practices maintain strict criteria and thoroughly educate family members and other caregivers.<sup>11</sup>

As you can see, about two-thirds of nurses reported that recommended changes to PCA use have been implemented in their practice settings. See "Keep Your Patient Safe during PCA" in the January issue of *Nursing2008*\* for a more detailed discussion.

#### ■ How confident are you?

20. On a scale of 1 (not confident) to 5 (very confident), how confident are you that you answered most of the questions correctly?

See *Does your knowledge match your confidence?* for a correlation of respondents' confidence level with correct answers to all of the first 14 questions. Although 56% chose a 4 or 5 confidence rating, indicating a high level of confidence, only about 21% of these respondents answered all 14 questions correctly.

The questions most often answered incorrectly reveal some common themes. Nurses still need education about how to assess pain intensity levels accurately, consistently, and objectively. Trying to correlate vital signs with pain level and concern about clock-watching and other behaviors associated with "drug seeking" were common pitfalls. Other areas of misunderstanding involve the appropriate use of NSAIDs and the no-ceiling effect of opioids. And although most nurses know that I.M. injections are no longer recommended for pain control, a few nurses still haven't gotten the word.

Overall, however, survey results were positive. Despite



their concerns about addiction, the nurses weren't afraid to give opioids to patients with a diagnosis of chronic low back pain. This is definitely a change in attitude. Nurses also understand that placebos shouldn't be used to test whether a patient's pain is real, and they understand the effects of chronic pain, such as loss of functionality and depression. Most also know that neuropathic pain requires a specialized treatment plan. Nurses recognized one of the newest entries into the pain assessment toolbox, behavioral pain scales, as a good way to assess pain in special patient populations. It's encouraging to see that most nurses have let go of myths and misperceptions about opioid use.

I appreciate the efforts of nurses who took the time to complete this survey. I hope this report will help educate all clinicians about pain management concepts and best-practice interventions. ♦

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## Nursing2008 Pain management survey report

**GENERAL PURPOSE** To provide an overview of the current standards and best practices of pain management. **LEARNING OBJECTIVES** After reading the preceding article and taking this test, you should be able to: **1.** Identify key principles of pain assessment. **2.** Identify aberrant drug-related behaviors in patients with chronic pain. **3.** Identify key principles of pain management.

### 1. This survey identified the need for more education in

- a. pain assessment.
- b. using vital signs as indicators of patient pain.
- c. identifying withdrawal symptoms.
- d. assessing physicians' prescribing patterns.

### 2. The best way to tell if a communicative patient is experiencing pain is to

- a. observe for changes in his vital signs.
- b. evaluate his level of anxiety.
- c. ask him.
- d. note the last time he received pain medication.

### 3. Which statement about I.M. injections used to deliver analgesia is true?

- a. They're the gold standard for relieving acute pain.
- b. They're discouraged in current practice.
- c. They allow consistent medication absorption.
- d. They rarely damage muscle tissue.

### 4. Which of the following best describes the relationship between pain and sleep?

- a. Sleep is a reliable indicator of pain relief.
- b. A sleeping patient is a comfortable patient.
- c. A sleeping patient has a tolerable amount of pain.
- d. A patient may sleep despite pain.

### 5. Which statement is true about patients with chronic pain?

- a. Few suffer from depression.
- b. They rarely become suicide risks.
- c. They accommodate to higher pain levels.
- d. They have a very high incidence of addiction.

### 6. Treating a patient's depression

- a. makes him more aware of his physical pain.
- b. can make controlling his pain easier.
- c. can lead to deterioration in functional ability.
- d. has no relationship to chronic pain.

### 7. Close observation of a communicative patient's behavior

- a. is a more reliable indicator of pain than his self-report.
- b. distinguishes chronic from acute pain episodes.
- c. allows you to modify the patient's self-rated pain report.
- d. is no substitute for a patient's self-rated pain report.

### 8. One study showed that the health care providers scoring lowest in matching patients' self-rated pain levels were

- a. house officers.
- b. attending physicians.
- c. nurses.
- d. medical fellows.

### 9. Which statement about assessing pain in nonverbal patients is correct?

- a. Behavioral pain scale use is uncommon.
- b. The Joint Commission doesn't require pain assessments for nonverbal patients.
- c. The Payen behavioral pain scale is best for patients with advanced dementia.
- d. Behavioral pain scales are effective.

### 10. Which statement about patient behaviors is true?

- a. Most patients who watch the clock for their next dose of pain medication are addicted.
- b. Clock-watching is predictive of addiction.
- c. Patients who know the exact time of their next pain medication probably have undertreated pain.
- d. Addicted and undertreated patients exhibit identical behavior patterns.

### 11. Patients who exhibit behaviors such as clock-watching should be viewed as

- a. drug seeking.
- b. opioid-dependent.
- c. pain relief seekers.
- d. chronic complainers.

### 12. Which percentage of nurses responding to this survey said that clock-watching is a sign of addiction?

- a. 20%
- b. 30%
- c. 40%
- d. 50%



## ENROLLMENT FORM Nursing2008, June, Nursing2008 Pain management survey report



### A. Registration Information:

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Registration Deadline: June 30, 2010

Contact hours: 3.0 Pharmacology hours: 0.0 Fee: \$27.95

☐ LPN ☐ RN ☐ CNS ☐ NP ☐ CRNA ☐ CNM ☐ other \_\_\_\_\_  
 Job title \_\_\_\_\_ Specialty \_\_\_\_\_  
 Type of facility \_\_\_\_\_ Are you certified? ☐ Yes ☐ No  
 Certified by \_\_\_\_\_  
 State of license (1) \_\_\_\_\_ License # \_\_\_\_\_  
 State of license (2) \_\_\_\_\_ License # \_\_\_\_\_  
☐ Please fax my certificate to me.  
☐ From time to time, we make our mailing list available to outside organizations to announce special offers. Please check here if you do not wish us to release your name and address.

### B. Test Answers: Darken one circle for your answer to each question.

1. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	8. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	15. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	22. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	29. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d
2. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	9. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	16. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	23. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	30. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d
3. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	10. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	17. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	24. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	31. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d
4. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	11. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	18. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	25. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	32. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d
5. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	12. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	19. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	26. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	33. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d
6. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	13. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	20. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	27. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	34. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d
7. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	14. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	21. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	28. <input type="radio"/> a <input type="radio"/> b <input type="radio"/> c <input type="radio"/> d	

### C. Course Evaluation\*

- 1. Did this CE activity's learning objectives relate to its general purpose? ☐ Yes ☐ No
- 2. Was the journal home study format an effective way to present the material? ☐ Yes ☐ No
- 3. Was the content relevant to your nursing practice? ☐ Yes ☐ No
- 4. How long did it take you to complete this CE activity? \_\_\_\_\_ hours \_\_\_\_\_ minutes
- 5. Suggestion for future topics \_\_\_\_\_

### D. Two Easy Ways to Pay:

- ☐ Check or money order enclosed (Payable to Lippincott Williams & Wilkins)
- ☐ Charge my ☐ Mastercard ☐ Visa ☐ American Express

Card # \_\_\_\_\_ Exp. date \_\_\_\_\_

Signature \_\_\_\_\_

\*In accordance with the Iowa Board of Nursing administrative rules governing grievances, a copy of your evaluation of the CE offering may be submitted directly to the Iowa Board of Nursing.

NO608B



**13. Which of the following is *least* predictive of addictive behavior?**

- a. selling prescription medication
- b. requesting specific drugs
- c. borrowing another patient's medication
- d. prescription forgery

**14. Which of the following is *most* predictive of addictive behavior?**

- a. concurrent use of illicit drugs
- b. aggressive complaining about needing higher drug doses
- c. obtaining similar drugs from other medical sources
- d. unapproved use of drugs to treat other symptoms

**15. Which statement about PCA is true?**

- a. PCA has been linked to rising patient-addiction rates.
- b. It allows the patient to give himself intermittent bolus doses of medication.
- c. It's been cited by The Joint Commission for ineffective pain control.
- d. It's a good method of pain control for all patients.

**16. PCA with basal infusion**

- a. is recommended for opioid-naïve patients.
- b. typically adds a great deal to pain relief.
- c. may cause oversedation.
- d. eliminates the need for a patient to give himself bolus doses.

**17. PCA with basal infusion may be *most* appropriate to treat**

- a. a sedated patient.
- b. a nonverbal patient.
- c. an opioid-naïve patient with acute pain.
- d. an opioid-tolerant patient with chronic pain.

**18. Opioid polymorphism is defined as**

- a. differences in patient response to opioids based on physiology.
- b. a patient's need for multiple types of pain relievers.
- c. the medication protocol needed for chronic pain.
- d. differences in chemical structure of various opioids.

**19. What is *not* true about opioid polymorphism?**

- a. It explains why a patient may respond better to some opioids than to others.
- b. Activation of the medication depends on enzyme availability for opioid binding to mu sites.
- c. Differences in kappa opioid binding sites account for different patient responses to opioids.
- d. At least 45 types of opioid binding site variations have been identified.

**20. Neuropathic pain differs from musculo-skeletal pain because it**

- a. includes the compression of tendons by bone.
- b. rarely responds to a combination of medications.
- c. can be relieved by antidepressants alone.
- d. results from nerve rather than muscle injury.

**21. Which statement about opioid dosing is *incorrect*?**

- a. Morphine has no ceiling on the degree of pain relief it provides.
- b. An opioid's dosage is limited when combined with another drug with a dosage ceiling.
- c. Opioid dosages aren't limited by adverse reactions.
- d. Intravenous opioids are easily titrated upward to effect.

**22. Some oncology patients on chronic opioid therapy**

- a. experience adverse reactions to relatively low dosages.
- b. safely receive very high opioid dosages.
- c. have dosages titrated according to the type of cancer they have.
- d. haven't developed opioid tolerance.

**23. Nonsteroidal anti-inflammatory drugs**

- a. may receive a black-box warning concerning risks in the near future.
- b. are appropriate after cardiac surgery.
- c. are most effective at higher doses over a longer period of time.
- d. increase the risk of myocardial infarction and stroke.

**24. Which may be a better indicator of pain medication efficacy than a numeric pain rating?**

- a. the amount of time a patient sleeps at night
- b. your clinical observation of her behavior
- c. her ability to care for herself
- d. her adherence to her opioid contract

**25. Which statement is true about placebo use?**

- a. Some patients have a positive response to placebos, which have no active ingredients.
- b. A positive response to a placebo proves that the patient had no pain.
- c. Placebo use is a valid interim intervention for pain relief before the next scheduled dose is due.
- d. Placebo use is a way to detect if a patient is drug seeking.

**26. A patient should receive a placebo only if**

- a. he's likely to respond positively to it.
- b. clinicians need to determine if his pain is real.
- c. all other pain medication has failed.
- d. he's taking part in research and has given informed consent.

**27. In acute care settings, patients who abuse substances**

- a. are increasing in number.
- b. are decreasing in number.
- c. shouldn't receive opioids.
- d. can be easily treated to manage acute pain.

**28. Which of the following is a chronic neurobiologic disease characterized by the four C's?**

- a. polymorphism
- b. tolerance
- c. dependency
- d. addiction

**29. The physical state that occurs when a patient becomes accustomed to the regular use of an opioid is called**

- a. polymorphism.
- b. tolerance.
- c. dependency.
- d. addiction.

**30. The percentage of patients with chronic pain who become addicted after taking opioids for 1 year is about**

- a. 5%.
- b. 10%.
- c. 25%.
- d. 50%.

**31. Fear of addiction and misunderstanding of dependency may lead to all of the following *except***

- a. labeling patients as drug seekers.
- b. appropriate pain management.
- c. misinterpreting drug-related behaviors.
- d. undertreating pain.

**32. Which statement about opioid addiction and dependence is true?**

- a. Patients who are drug dependent are also addicted.
- b. Patients who are addicted are also drug dependent.
- c. In an addicted patient, abruptly stopping the drug won't cause withdrawal signs and symptoms.
- d. Opioid dependence and addiction have no relationship to each other.

**33. For PCA safety, The Joint Commission recommends all of the following *except***

- a. standardized order sets.
- b. a second nurse's signature for all dosing changes.
- c. standardized PCA solutions and concentrations.
- d. PCA by proxy.

**34. Among survey respondents who indicated a high confidence level, what percentage answered all of the first 14 survey questions correctly?**

- a. 21%
- b. 31%
- c. 41%
- d. 51%